

ACO Accelerated Development Learning Session

San Francisco, CA
September 15-16, 2011

Module 3B. Connecting Providers and Managing High-Risk Patients



September 16, 2011
8:15–10:15 a.m.

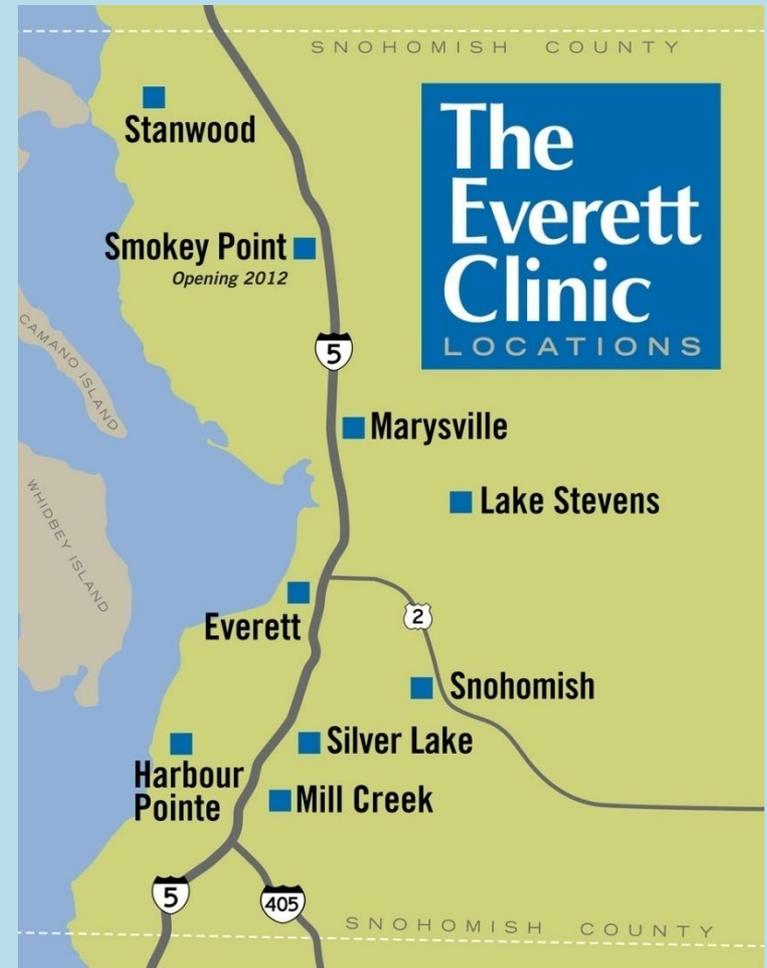
Steve Jacobson, MD
Jennifer Wilson Norton, RPh, MBA
The Everett Clinic

DISCLAIMER. The views expressed in this *presentation* are the views of the speaker and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The materials provided are intended for educational use, and the information contained within has no bearing on participation in any CMS program.



The Everett Clinic (TEC) Overview

- Largest independent medical group (WA)
- 8 satellite locations throughout Snohomish County
 - Smokey Point (opening 2012)
 - 8 walk-in clinics
- 5th largest private employer in Snohomish County
 - 1,700 employees
 - 415 health care providers
 - 315 physicians (45 hospitalists)
 - 100 advanced clinical practitioners



The Everett Clinic

Services:

- More than 40 diverse medical specialties (primary care and specialty services)
- Advanced imaging center
- Two surgery centers
- Regional cancer center
- Three regional pharmacies

Patients:

- 295,000 active patients
 - 850,000 visits annually
 - 25,000 surgeries annually
 - 41,000 Medicare patients

Our Culture

- Practice evidenced-based medicine
- And, evidence-based leadership
- Patient centered
- Treat people with courtesy and respect
- Listen to staff
- Offer flexibility
- Culture of excellence and innovation
- Use Lean principles
- Integrated technology
- Recognition and rewards

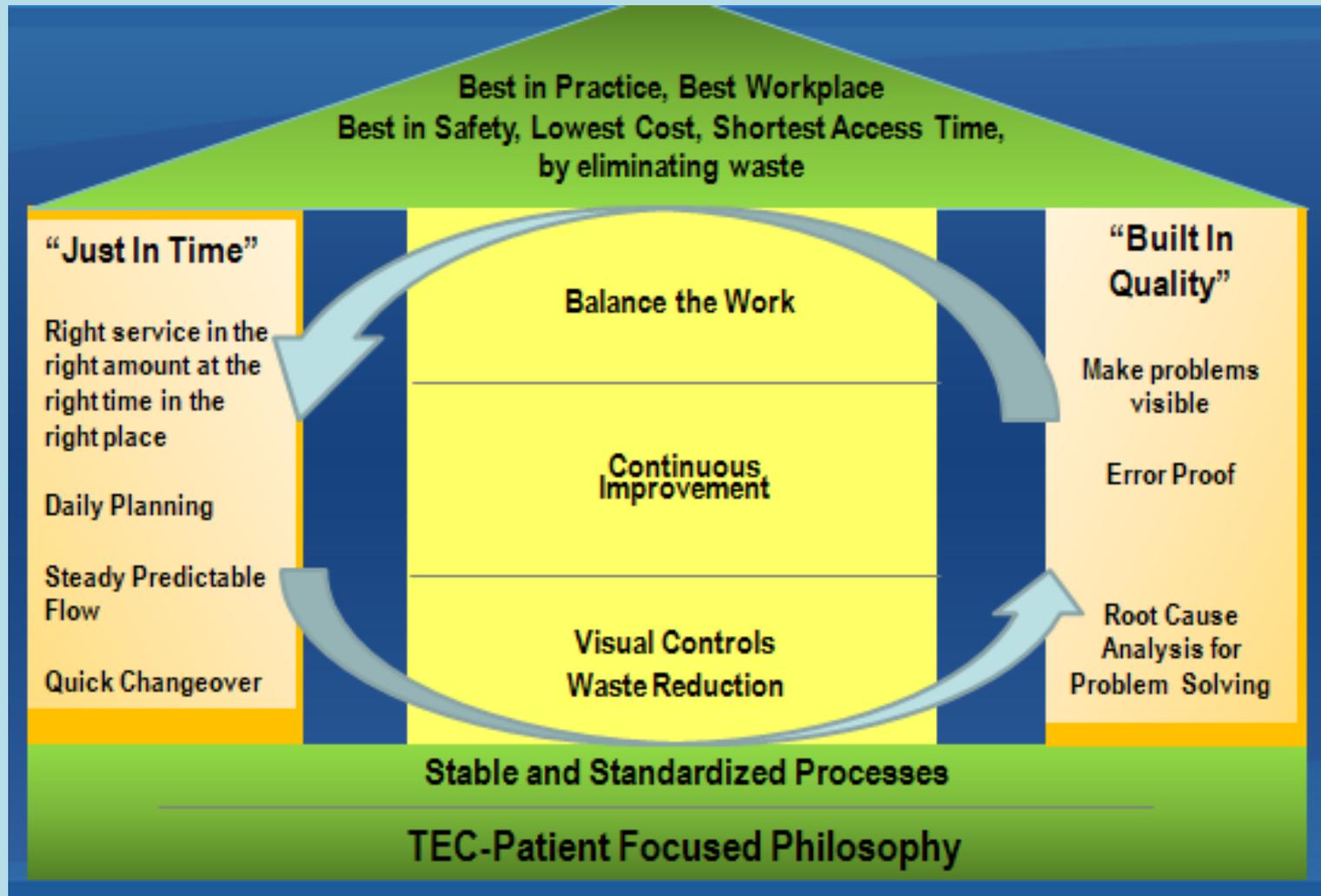


And we like to have fun!

Our Core Values

- We do what is right for each patient
- We provide an enriching and supportive workplace
- Our team focuses on value: service, quality, and cost

TEC Management and Improvement System



1912

The 'Great Divide'

“...for the first time in human history, a random patient with a random disease consulting a doctor chosen at random stands a better than 50/50 chance of benefitting from the encounter.”

~Harvard Professor L. Henderson

(Harris, Richard. A Sacred Trust. New York, NY: New American Library, 1966)

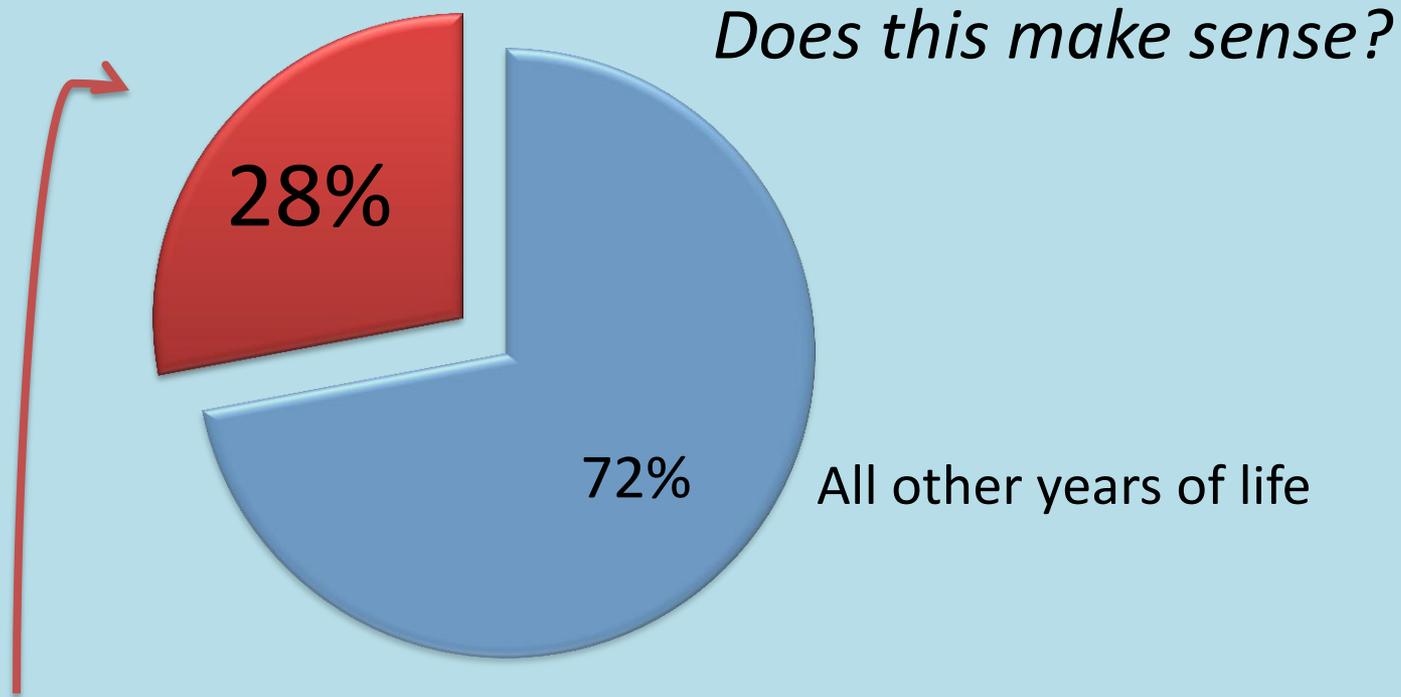
ACO Pitfalls

- Overestimating organizational ability to
 - Manage risk
 - **Use electronic health records**
 - **Report performance measures**
 - **Implement standardized care management protocols**
- Failure to balance interests and engage stakeholders
 - Hospitals, primary care providers, specialists
 - Governance and management processes
 - Patients and families
 - Contractual relationships with the most cost-effective specialists
 - Laws and regulations
- **Failure to recognize interdependencies and integrate beyond structural level**



Singer, S. & Shortell, S. "Implementing Accountable Care Organizations: Ten Potential Mistakes and How to Learn From Them." JAMA. August 9, 2011. <http://jama.ama-assn.org/content/early/2011/08/05/jama.2011.1180.extract>

Spending



Percent of Medicare spending on recipients' final year of life

DATA:
Medicare Payment Advisory Commission
Article: "USA, Inc." Bloomberg Businessweek.
Feb 28 – Mar 6, 2011.

Learning Objectives

- Utilize different health plan and data techniques to identify complex patients
- Review The Everett Clinic's key care management programs, results, and lessons learned
- Gain an increased understanding of how organizations can utilize their electronic health records (EHR) and other electronic tools to manage complex patients



Our Journey in Managing Complex Populations

- Identifying the complex patient
- CMS PGP P4P Demonstration Program
- Boeing IOCP Pilot Program
- Partners in Palliative Care
- Advanced Care Coordination
- Transition Management
- EHR and Other Electronic Systems and Tools

Identifying Complex Populations

- Prospective models provide greater ability to focus care and resources
- Models used to date
 - Health plan predictive modeling
 - Higher utilizers of hospital-based services
 - Review of readmissions
 - Team referral at discharge or other key interfaces

CMS Medicare P4P Demo Program

- 5-year project – ended April 1, 2010
- 9,000 Medicare Fee for Service patients (TEC)
- 32 quality improvement metrics
- Must achieve >2% points in total cost savings compared to the local trend line
- Savings shared annually between CMS and providers based on quality performance

CMS PGP Demo Quality Metrics

Diabetes Mellitus	Congestive Heart Failure	Coronary Artery Disease	Hypertension & Cancer Screening
<i>HbA1c Management</i>	LVEF Assessment	Antiplatelet Therapy	Blood Pressure Screening
HbA1c Control	<i>LVEF Testing</i>	Drug Therapy for Lowering LDL Cholesterol	Blood Pressure Control
Blood Pressure Management	Weight Measurement	Blood Pressure	Blood Pressure Plan of Care
<i>Lipid Measurement</i>	Blood Pressure Screening	<i>Lipid Profile</i>	<i>Breast Cancer Screening</i>
LDL Cholesterol Level	Patient Education	LDL Cholesterol Level	Colorectal Cancer Screening
<i>Urine Protein Testing</i>	Beta-Blocker Therapy	Antiplatelet Therapy	Blood Pressure Screening
<i>Eye Exam</i>	Ace Inhibitor Therapy	Ace Inhibitor Therapy	
Foot Exam	Warfarin Therapy		
Influenza Vaccination	Influenza Vaccination		
Pneumonia Vaccination	Pneumonia Vaccination		

CMS PGP Demo Results

- TEC has improved the quality of care and moderated (slightly) the cost trend line
- Total gain sharing with TEC ~ \$250,000
- Cost to TEC ~ \$500,000 annually
- We have been rewarded with tremendous learning opportunities

Key Learnings from PGP Demo

- Disease management: Diabetes, congestive heart failure, coronary artery disease, hypertension anchored in EHR
- Preventive care
- Palliative care
- Hospital coach: Seamless communication during care transition
- Post hospitalization visits \leq 5 days
- Importance of diagnostic coding

Boeing IOCP Project

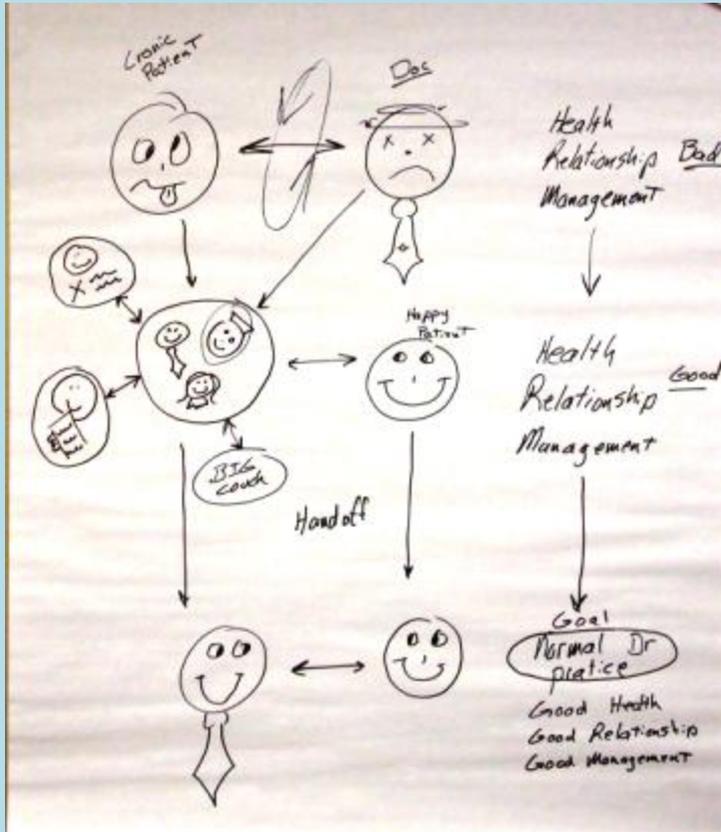
- Commercial aged population
- Request by Boeing to try a new care model to improve quality and decrease total cost of care
- TEC Model: Carve out primary care physician (PCP)/partnered with care management RN + behavioral health + clinical pharmacist
- Annual program cost~ \$300,000

Year One Results All Sites – Compared to Baseline

Measure	Results
% change in annual per capita spending by patients and Boeing, compared to a matched control group	-20%
% change in SF12 physical functioning	+14.8%
% change in SF12 mental functioning	+16.1%
% change in patient-rated “received care as soon as needed”	+17.6%
% change in average patient-reported work days missed in last 6 months	-56.5%

Patient Perspective

Boeing Audio



Key Learnings

- High-performing RN Care Managers anchor patient and team
- Behavioral health key in complex patient care
- Multidisciplinary team rounds = MD + RN + RPh provide opportunities for continued care improvement
- Medication compliance awareness increased by using pharmacy claims data
- Hospital/ER/Urgent Care electronic tracking tool essential for coordinating patient's care

Care Management Programs 2011–2012 at TEC

- Partners in Palliative Care
- Advanced Care Coordination
- Transition Management
- New PCP Model

Two Patients



Patient A



Patient B

Key Elements for All Programs

- RN Care Manager anchor
- Right care at the right place for patients
- Flagging in electronic systems to identify patients
- Proactive calls at key intervention points
- ACORN Screening Tool and Behavioral Health interventions, including clinical team support

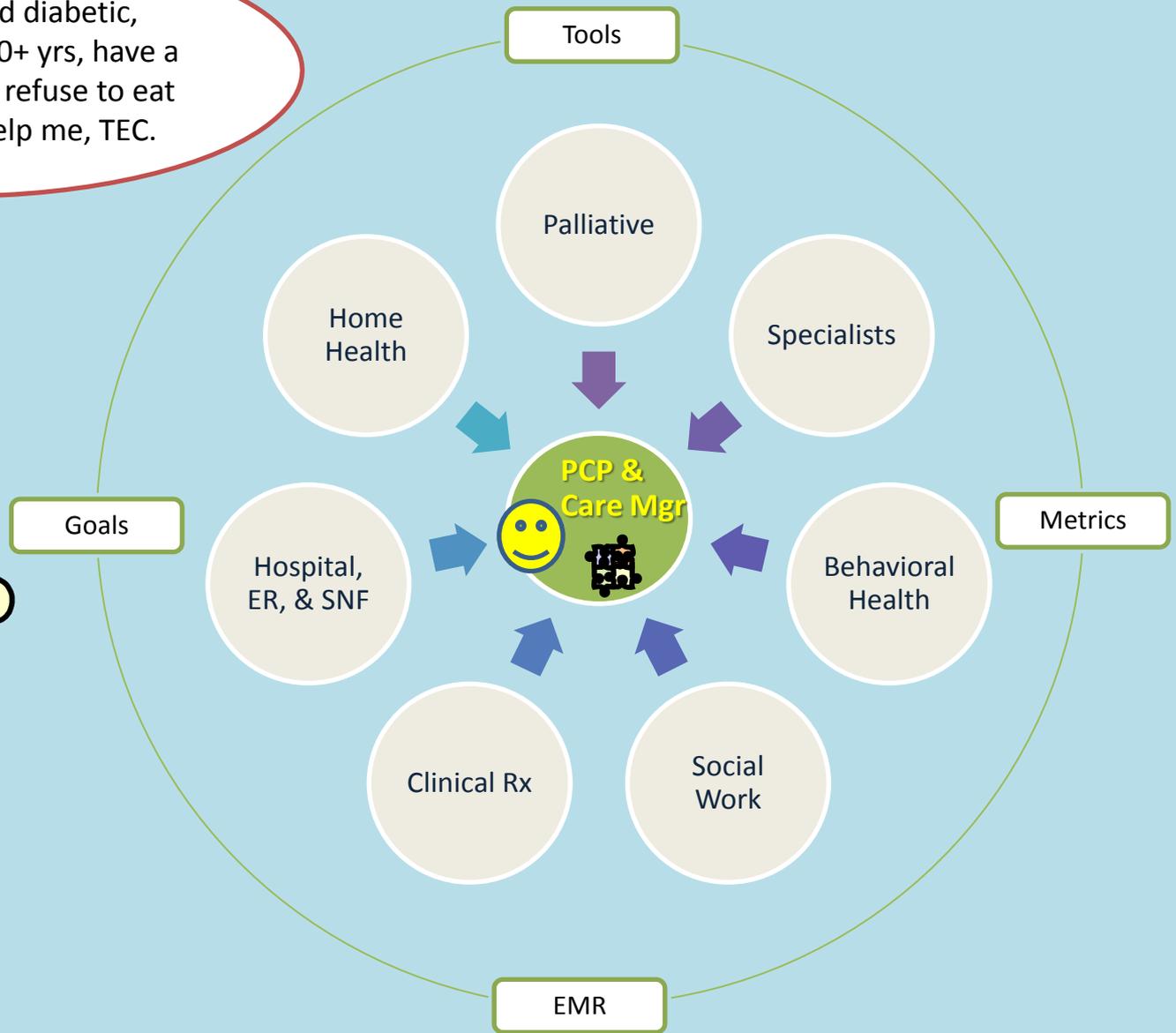
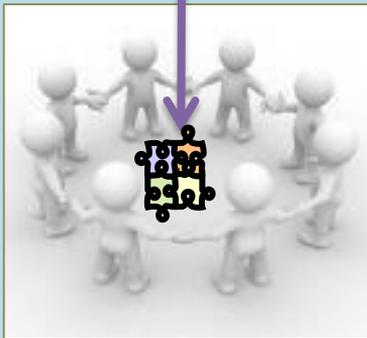
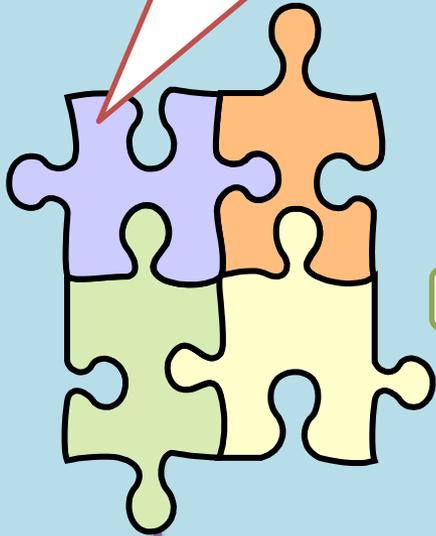
Partners in Palliative Care

- Jointly led by Providence Hospice and The Everett Clinic
- Patients do not need to be homebound
- Patients are eligible if their provider would not be surprised if they passed away in the next 2 years
- Program annualized cost ~\$700,000

Advanced Care Coordination

- Took on key elements of our experiences—expanded to all TEC primary care sites
- Integrating behavioral health, social work, and clinical pharmacy
- Rapid access to care team is critical
- Challenging to size and scale it across populations and locations

I am a 52-year-old diabetic, obese, smoker for 30+ yrs, have a high-stress job, and refuse to eat anything green. Help me, TEC.



Transition Management

- Based on the work of Eric Coleman, MD
- Team at the hospital and skilled nursing facility (SNF)
- Focus on the four pillars
 - Why are they in the hospital/SNF?
 - Where is their next touchpoint for care?
 - What red flags should the patient be aware of?
 - Medication management

Key Team Traits and Skill Enhancement

- Engaged providers are key
- Right skilled teammates to do the work
- Clinical teams able to work on a level playing field
- Enjoy complex patients
- Embrace and deliver a holistic approach to care, including social and psychosocial issues
- Population management
- Challenges in scaling up



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Hospice Care

- Will this patient likely die in the next 6 months?
- Hospice patients live longer than similar aggressively managed patients with less pain and improved patient and family satisfaction and, on average, \$8,000 less cost of care
- Cost of care: “Letting Go” Atul Gawande

New PCP Model – Under Development

- Team cares for smaller number of very complex/fragile patients
- Scheduling template: two patients per hour with time for virtual visits (phone, MyChart)
- Pilot planned for January 2012
- New physician compensation model

Physician Compensation

Current:

- 95% Production, RVU based
- Care Coordination Stipend
 - Panel size x HCC RAF Score x Conversion Factor

Physician Compensation *continued*

Proposed:

- Base Salary
- Incentive Bonus
 - Patient satisfaction – Press Ganey
 - Quality measures
 - Documentation and coding
 - Institutional utilization
 - ER
 - Inpatient
 - SNF

TEC Information Technology Approach

- Right tools to the right audience
 - Clinic wide
 - Satellite
 - Microteam
- Make it easy to do the right thing
- Continual improvement – our journey began over 5 years ago
- Reality of multiple systems, internal and external data

Electronic Medical Record (EMR) Front Page (“Snapshot”)

- In-Basket
- On-Line Information Resource
 - UpToDate
- Links *
- Disease Management *
- Reports *
- Standard Work *

EPIC Front Page

The screenshot shows the EPIC front page with several key sections:

- Clinical Staff:** A list of staff members and their roles, including "Wic Check In Hourly By Weekday", "Wic Check In Hourly Chart", "Wic Check In Hourly By Location", "Wic Check In Hourly By Location Across Date Range", and "Total Tec Wic Check In Hourly".
- In Basket Glance:** A table showing the current status of the user's in-basket items as of 8/31/2011 3:04:42 PM.

Type	Total	New
Results	15 (14 !)	-
Rx Request	1	-
Patient Call	17 (10 !)	2
Encounters	4	2
- 65+ ER/PEMC Discharge Link:** A notification stating: "This link has been renamed to 'TEC Providence Patient Tracker' and is now near the bottom of the section labeled 'My Links'".
- Up To Date - CME:** A section with a link to "UpToDate".
- My Links:** A section containing various links, with "My Links" and "Standard Work Guidelines" circled in red.
 - Reports:** A sub-section with a red circle around its header, containing a list of reports such as "After Visit Summary", "In Basket Open Item Lag Time", "Lab Results Review Turnaround Time", "Telephone Encounter Closed in 4 Hours", "Telephone Encounter by Clinical Staff", "Standard Rooming Vitals", "Refill Encounter Closed 24/48/72 Hrs", "Refill Encounter Closed In 1/4/8 Hours", "Result Review 24 Hours", and "In Basket Message Turnaround".
 - Standard Work Guidelines:** A sub-section with a red circle around its header, containing a list of guidelines such as "After Visit Summary Guidelines", "Lab Results Review Guidelines", "Telephone Encounter Guidelines", "Telephone Encounter by Clinical Staff Guidelines", and "Standard Rooming Guidelines".
- Websites:** A list of various websites and resources, including "2009 Team Performance", "10-year CVD Risk Calculator", "10-year Who Fracture Risk (FRAX)", "CDC Immunization Schedule", "CMR - Pat Notes & Labs Only", "Child Profile", "Epic Upgrade Documentation", "Epocrates", "Equivalent Dosing of Medications", "Flu Services", "Grand Rounds", "HEAL-WA", "Health Advisor", "Institutional Care", "Pain Management Tools", "Patient Satisfaction", "Pharmacology Online", "Prior Authorization Phone Numbers", "ProvCare", "Secure Access - L&I Secure Claims", "Senior Care Resources", "Stentor", "Surgeons Schedule", "Surgeon TEC Economic Updates", "Surgeon TEC Epic Homepage", "TEC TEC Intranet", "TEC TEC Phone Directory", "TEC TEC Providence Patient Tracker", and "The Everett Clinic Home Page".

- Links
- Reports
- Standard Work Guidelines

EMR Front Page (“Snapshot”)

Links

- CDC
- Epocrates
- Pharmacology On-Line
- Institutional Care
- ProVCare
- **TEC Providence Patient Tracker**

Hyperspace - SNOH FAMILY MEDICINE - Production - STEVEN J

Patient Call Encounters

Epic MyEpic Schedule In Basket Chart Encounter Telephone Call Refill Enc Appts View Sched Secure Print Log Out

Zzjourney,Janscan L Zzjourney,Janscan L

MyEpic

Clinical Staff Edit

Wic Check In Hourly By Weekday
Wic Check In Hourly Chart
Wic Check In Hourly By Location
Wic Check In Hourly By Location
Across Date Range
Total Tec Wic Check In Hourly

65+ ER/PEMC Discharge Link

This link has been renamed to "TEC Providence Patient Tracker" and is now near the bottom of the section labeled "My Links".

Up To Date - CME Edit

UpToDate

In Basket Glance Edit

Current as of 8/31/2011 3:04:42 PM.

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Disease Management

Disease Management Portal Page
Enter New Pap Card
Pap Card Review

My Links Edit

Websites

- 2009 Team Performance
- 10-year CVD Risk Calculator
- 10-year Who Fracture Risk (FRAX)
- CDC Immunization Schedule
- CMR - Pat Notes & Labs Only
- Child Profile
- Epic Upgrade Documentation
- Epocrates
- Equivalent Dosing of Medications
- Flu Services
- Grand Rounds
- HEAL-WA
- Health Advisor
- Institutional Care
- Pain Management Tools
- Patient Satisfaction
- Pharmacology Online
- Prior Authorization Phone Numbers
- ProvCare
- Secure Access - L&I Secure Claims
- Senior Care Resources
- Stentor
- TEC Economic Updates
- TEC Epic Homepage
- TEC Intranet
- TEC Phone Directory
- TEC Providence Patient Tracker
- The Everett Clinic Home Page

Reports Edit

TEC-IS Reports

- After Visit Summary
- In Basket Open Item Lag Time
- Lab Results Review Turnaround Time
- Telephone Encounter Closed in 4 Hours
- Telephone Encounter by Clinical Staff
- Standard Rooming Vitals
- Refill Encounter Closed 24/48/72 Hrs
- Refill Encounter Closed In 1/4/8 Hours
- Result Review 24 Hours
- In Basket Message Turnaround

Standard Work Guidelines

- After Visit Summary Guidelines
- Lab Results Review Guidelines
- Telephone Encounter Guidelines
- Telephone Encounter by Clinical Staff Guidelines
- Standard Rooming Guidelines

EPIC Links

TEC Prov Patient Tracker

PEMC ER/Hosp Discharged Patients who Need Follow Up

[Standard Work- PEMC ER-Hosp Discharge Telephone Follow Up Process.doc](#)

[Refresh Page](#) [Exit](#)

Note: Patients will stop appearing 7 days after an admit and reappear at discharge for another 7 days

Location: Dept: Patient Type: Search Patient HX/Name: Search PCP Name: Age: From: To:

ER VISIT

	HXNO	PAT_NAME	BIRTHDATE	Age	ADM_DT	DISCH_DT	ADM_DIAGNOSIS	ATTEND_PHY	DISCH_STAT	EPIC_PCP	Primary Ins
		Tommy Jones		7	08/30/2011	08/30/2011 12:08	PAIN DENTAL		HOME	SHER, STEPHEN G	
		Susie Lu		4	08/28/2011	08/28/2011 06:08	FEVER-CHILD		HOME	JACOBSON, STEVEN C	
		Abe Lincoln		62	08/24/2011	08/25/2011 05:08	FOREIGN IN THROAT-EMS		HOME	JACOBSON, STEVEN C	

HOSPITAL DISCHARGE

	HXNO	PAT_NAME	BIRTHDATE	Age	ADM_DT	DISCH_DT	ADM_DIAGNOSIS	ATTEND_PHY	DISCH_STAT	EPIC_PCP	Primary Ins
		Marc Southfield		64	08/27/2011	08/29/2011 02:08	SYNCOPE DEHYDRATION		HOME	MCCLINCY, MICHAEL S	

HOSPITAL ADMIT

	HXNO	PAT_NAME	BIRTHDATE	Age	ADM_DT	DISCH_DT	ADM_DIAGNOSIS	ATTEND_PHY	DISCH_STAT	EPIC_PCP	Primary Ins
		Becky Neumann		94	08/30/2011		*PAL* - CVA UNSPECIFIED TYPE			SALAZAR, MIRIAM L	
		Jay Smith		44	08/28/2011		ABDOMINAL PAIN/ACUTE RENAL FAILU			MCCLINCY, MICHAEL S	

EMR Front Page (“Snapshot”)

Disease Management

- Patient Management Reports
- Dashboards
- Quality Admin Reports
- Targeted Quality Scorecards
- UpToDate reports

Hyperspace - SNOH FAMILY MEDICINE - Production - STEVEN J

MyEpic Schedule In Basket Chart Encounter Telephone Call Refill Enc Apts View Sched Secure Print Log Out

Zzjourney,Janscan L Zzjourney,Janscan L

MyEpic

Clinical Staff Edit

Wic Check In Hourly By Weekday
Wic Check In Hourly Chart
Wic Check In Hourly By Location
Wic Check In Hourly By Location
Across Date Range
Total Tec Wic Check In Hourly

In Basket Glance Edit X

Current as of 8/31/2011 3:04:42 PM.

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65+ ER/PEMC Discharge Link X

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Disease Management

Disease Management Portal Page
Enter New Pap Card
Pap Card Review

Reports Edit

TEC-IS Reports

- After Visit Summary
- In Basket Open Item La
- Lab Results Review Tur
- Telephone Encounter C
- Telephone Encounter b
- Staff
- Standard Rooming Vita
- Refill Encounter Closed
- Hrs
- Refill Encounter Closed
- Hours
- Result Review 24 Hours
- In Basket Message Tur

Standard Work Guidel

- After Visit Summary Gu
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- Standard Rooming Guid

Up To Date - CME Edit X

UpToDate

My Links Edit

Websites

2009 Team Performance
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TEC Intranet
TEC Phone Directory
TEC Providence Patient Tracker
The Everett Clinic Home Page

Disease Management

Disease Management Portal Page
Enter New Pap Card
Pap Card Review

Disease Management

Disease Management

Quality - Health Maintenance & Disease Management Portal

Welcome Embertson, Mari | My Site | My Links

Quality - Health Maintenance & Disease Management Portal

Quality - Health Maintenance & Disease Management Portal

Targeted Quality Scorecards

- Targeted Quality Scorecard by Provider
- Targeted Quality Scorecard by Location**
- Primary Care Targeted Quality Scorecard
- TEC Targeted Quality Scorecard

Up to Date Reports:

- Provider Performance Report**
- Location Performance Report
- Performance Report by Specialty
- Primary Care Performance Report
- TEC Performance Report
- Non Primary Care Performance Report

Announcements

There are currently no active announcements.

Patient Management Reports:

- CAD Registry Patient List by Providers
- Diabetes Registry Patient List by Providers**
- Hypertension Registry Patient List by Providers
- Registry Patients Due for Lipid Screening
- Registry Patients Due for Mammogram
- Registry Patients Due for DEXA Scan
- Registry Patients Due for Cervical Cancer Screening
- Registry Patients Due for Colon Cancer Screening
- Pediatric 19-35 Month Immunization Due Report
- Adolescent Immunization Due Report
- Everything Everybody Needs - Female
- Everything Everybody Needs - Male
- COPD Registry Patient List by Providers
- Heart Failure Registry Patient List by Provider

Quality Admin Reports:

- CAD Registry Statistics by Location and Department
- CAD Registry Statistics by Providers

Dashboards

URL

Section : 1 - The Everett Clinic (1)

Imms 19-35 Month

Section : 2 - Primary Care (2)

Health Maintenance - Compared by Location

Health Maintenance

Section : 3 - Specialty (2)

Imms 19-35 Months

Up to Date 55%

Section : 4 - Location (5)

Imms 19-35 Months

Up To Date 55%

Health Maintenance

Diabetes

Cervical Cancer Screening

Documents

Type	Title	Modified	Modified By	Checked Out To
	Criteria HM Prompts & BPAs	8/19/2011 12:47 PM	Nelson, Paige	
	July 2011 Immunization Defect Charts	8/16/2011 4:14 PM	Wachholz, Lynette ARNP	
	June 2011 Immunization Defect Charts	7/14/2011 8:47 AM	Wachholz, Lynette ARNP	
	May 2011 Immunization Defect Charts	6/20/2011 2:12 PM	Wachholz, Lynette ARNP	
	Apr 2011 Immunization Defect Charts	5/23/2011 12:11 PM	Wachholz, Lynette ARNP	
	Mar 2011 Immunization Defect Charts	4/15/2011 11:38 AM	Wachholz, Lynette ARNP	

Targeted Quality Scorecard

*Diabetes

*COPD

*Heart Failure

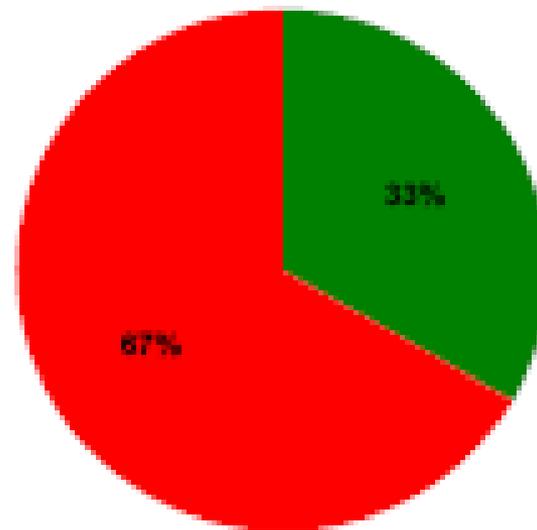
*Health Maintenance

The Everett Clinic 8/31/2011
For the whole you.

EVERETT CLINIC SNOHOMISH Targeted Quality Scorecard

	Metrics	Measure Description	Panel Size	Target	Provider Performance
Diabetes	HbA1c Control	Percent patients 18-75 years with HbA1c < 7.0%	503	40%	49.5%
	HbA1c Uncontrolled	Percent patients 18-75 years with HbA1c > 9.0%	503	<=13%	19.7%
	BP Control	Percent patients 18-75 years with BP < 130/80	503	25%	47.9%
	LDL-C Control	Percent patients 18-75 years with LDL-C <100 mg/dl	503	61%	50.1%
COPD	Spirometry	Percent of patients with active Chronic Obstructive Pulmonary Disease who got appropriate spirometry testing to confirm the diagnosis.	205	83%	18.0%
	Hospital Follow-up Visit	Patient with a discharge diagnosis of COPD seen within 7 days of hospital discharge.	8	60%	50.0%
Heart Failure	LVEF Assessment	Percentage of patients aged 18 years and older with a diagnosis of heart failure for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment is documented within a 12 month period	67	78%	74.6%
	Use of ACE or ARB, if LVSD	Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge	14	82%	78.6%
	Hospital Follow-up Visit	Patient with a discharge diagnosis of HF seen within 7 days of discharge	14	60%	64.3%
Health Maintenance	Screening for Depression if patient had DM, COPD or HF	Percent of patients with diagnosis of diabetes, COPD, or HF who have been screened for depression using ACORN during past 12 months (or who have current diagnosis of depression).	786	50%	21.1%
	Colorectal Cancer Screening	Percent of patients 50-75 years who had appropriate screening for colon cancer.	3269	70%	69.7%
	Tobacco Cessation Intervention	Percentage of patients 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.	1581	75%	44.4%

TEC Quality Metrics



■ At Target
 ■ Not at Target

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Diabetes Registry

*HbA1c

*BP

*LDL

*Eye Exam

*Foot Exam

The Everett Clinic
For the whole you.

Current as of 8/31/2011

Diabetes Registry Statistics by Location and Department - Detail

EVERETT CLINIC SNOHOMISH

Department Provider	Total Actv Patients	# and % Patients with HbA1c in last 6 months	# and %patients with HbA1c in control <7.0	% patients with HbA1c >9.0	Average HbA1c last 6 months	# and % Patients with BP < 130/80	# and % Patients with LDL in last year	# and % Patients with LDL <100 in last year	# and % Patients with Microalbumin in last year	# and % patients with Eye Exam in last year	# and % Patients with Foot Exam in last year
Family Praotice											
IHLE, LOREN J - 200	140	105 75.0%	67 47.9%	11 7.9%	7.2	72 51.4%	127 90.7%	80 57.1%	108 77.1%	87 62.1%	118 84.3%
JACOBSON, STEVEN C - 189	78	54 69.2%	32 41.0%	2 2.6%	7.2	50 64.1%	58 74.4%	38 48.7%	55 70.5%	41 52.6%	61 78.2%
MOCLINCY, MICHAEL S - 943	130	85 65.4%	41 31.5%	20 15.4%	7.6	49 37.7%	95 73.1%	63 48.5%	92 70.8%	70 53.8%	91 70.0%
MOCLINCY, WHITNEY PAIGE - 898	44	29 65.9%	17 38.6%	4 9.1%	7.2	20 45.5%	36 81.8%	23 52.3%	23 52.3%	15 34.1%	18 40.9%
Family Praotice:	382	273 88.8%	167 40.1%	37 8.4%	7.3	191 48.7%	318 80.8%	204 62.0%	278 70.9%	213 64.8%	288 73.6%
Internal Mediolne											
SALAZAR, MIRIAM L - 237	109	86 78.9%	49 45.0%	13 11.9%	7.4	55 50.5%	88 80.7%	50 45.9%	80 73.4%	67 61.5%	59 54.1%
WAY, JENNY Y - 877	67	51 76.1%	34 50.7%	5 7.5%	7.2	26 38.8%	61 91.0%	38 56.7%	57 85.1%	28 41.8%	43 64.2%
Internal Mediolne:	178	137 77.8%	83 47.2%	18 10.2%	7.3	81 48.0%	149 84.7%	88 60.0%	137 77.8%	95 64.0%	102 68.0%
EVERETT CLINIC SNOHOMISH	688	410 72.2%	240 42.3%	55 8.7%	7.3	272 47.8%	486 81.8%	292 61.4%	416 73.1%	308 64.2%	390 88.7%

UpToDate: Provider Performance Report

The Everett Clinic
For the whole you

Current as of 8/31/2011

HMDM Provider Performance Report

TEC PROVIDER: JACOBSON, STEVEN C - 189

PCP Panel Population: 1201

Registry Prompts	Registry Panel Size *	Provider Performance *	PCP Median *	Best Practice *
I. Health Maintenance				
Breast Cancer Screening	232	39.7%	49.6%	67.0%
Cervical Cancer Screening	239	66.1%	66.4%	81.0%
Colon Cancer Screening *	477	64.6%	70.3%	86.0%
Lipid Screening	462	85.1%	84.8%	93.0%
Osteoporosis Screening	67	77.6%	83.8%	94.0%
II. Disease Management				
Diabetic				
HgbA1c every 6 months	78	69.2%	66.7%	86.0%
HgbA1c < 7.0		41.0%	41.0%	57.0%
LDL annually		76.4%	82.0%	94.0%
LDL < 100		48.7%	46.6%	65.0%
BP annually		94.9%	94.2%	98.0%
BP < 130/80		64.1%	39.9%	61.0%
Eye Exam annually		52.6%	48.5%	64.0%
Microalbumin		70.5%	72.1%	89.0%
Hypertension				
BP annually	341	92.4%	92.9%	97.0%
BP under control * within 1 year		65.1%	56.7%	68.0%
HTN annual visit if last BP out of control (100 Pts.)		80.0%	77.0%	86.0%
Coronary Vascular Disease				
BP annually	52	94.2%	94.7%	99.0%
BP under control *		69.2%	64.1%	74.0%
LDL annually		86.5%	77.8%	91.0%
LDL < 100		59.6%	53.2%	70.0%
III. Total Unique Registry Patients: *				
Total Unique Registry patient without Mamm. registry *	899	46.4%	45.6%	
	892	51.5%	51.8%	

(*) Definitions
 Registry Panel Size: Patients seen at TEC within the last 2 years, based on PCP Identified in Epic
 Physician Performance: Percent registry patients on a provider's panel who have met criterion for given process or outcome metric, compared to PCP median

Legend: lowest quartile (red), 26-50th (orange), 51-75th (yellow), top quartile (green)

- Health Maintenance Screenings
- Disease Management Metrics
 - Diabetes
 - Hypertension
 - Coronary Vascular Disease
- Performance
 - Individual Provider
 - PCP Median
 - Best Practice

EMR Front Page (“Snapshot”)

Reports (examples)

- After Visit Summary
- Telephone Encounter Closed in 4 hours
- Standard Rooming Vitals
- In Basket Message Turnaround

Hyperspace - SNOH FAMILY MEDICINE - Production - STEVEN J

Patient Call Encounters

Epic MyEpic Schedule In Basket Chart Encounter Telephone Call Refill Enc Appts View Sched Secure Print Log Out

Zzjourney,Janscan L Zzjourney,Janscan L

MyEpic

Clinical Staff Edit

Wic Check In Hourly By Weekday
Wic Check In Hourly Chart
Wic Check In Hourly By Location
Wic Check In Hourly By Location Across Date Range
Total Tec Wic Check In Hourly

In Basket Glance Edit X

Current as of 9/31/2011 3:04:42 PM.

Type	Total	New
Results	15 (14 !)	-
Rx Request	1	-
Patient Call	17 (10 !)	2
Encounters	4	2

65+ ER/PEMC Discharge Link X

This link has been renamed to "TEC Providence Patient Tracker" and is now near the bottom of the section labeled "My Links".

Disease Management

Disease Management Portal Page
Enter New Pap Card
Pap Card Review

Reports Edit

TEC IS Reports

- After Visit Summary
- In Basket Open Item Lag Time
- Lab Results Review Turnaround Time
- Telephone Encounter Closed in 4 Hours
- Telephone Encounter by Clinical Staff
- Standard Rooming Vitals
- Refill Encounter Closed 24/48/72 Hrs
- Refill Encounter Closed In 1/4/8 Hours
- Result Review 24 Hours
- In Basket Message Turnaround

Standard Work Guidelines

- After Visit Summary Guidelines
- Lab Results Review Guidelines
- Telephone Encounter Guidelines
- Telephone Encounter by Clinical Staff Guidelines

Up To Date - CME Edit X

[UpToDate](#)

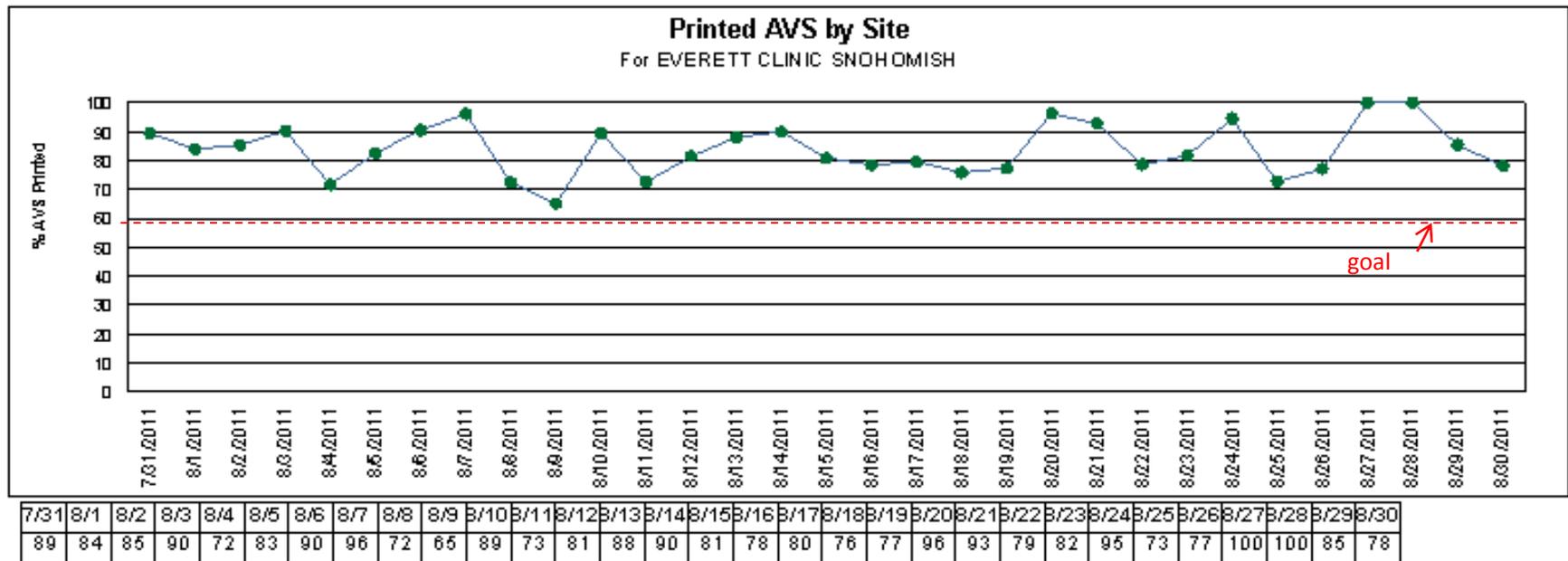
My Links Edit

Websites

- 2009 Team Performance
- 10-year CVD Risk Calculator
- 10-year Who Fracture Risk (FRAX)
- CDC Immunization Schedule
- CMR - Pat Notes & Labs Only
- Child Profile
- Epic Upgrade Documentation
- Epocrates
- Equivalent Dosing of Medications
- Flu Services
- Grand Rounds
- HEAL-WA
- Health Advisor
- Institutional Care
- Pain Management Tools
- Patient Satisfaction
- Pharmacology Online
- Prior Authorization Phone Numbers
- ProvCare
- Secure Access - L&I Secure Claims
- Senior Care Resources
- Stentor
- Surgeons Schedule
- Surgery Booking Slip
- TEC Economic Updates
- TEC Epic Homepage
- TEC Intranet
- TEC Phone Directory

After Visit Summary Report

EVERETT CLINIC SNOHOMISH



Telephone Encounters Report

The Everett Clinic
For the whole you.

TEC Telephone Encounters Closed In 4 Hours

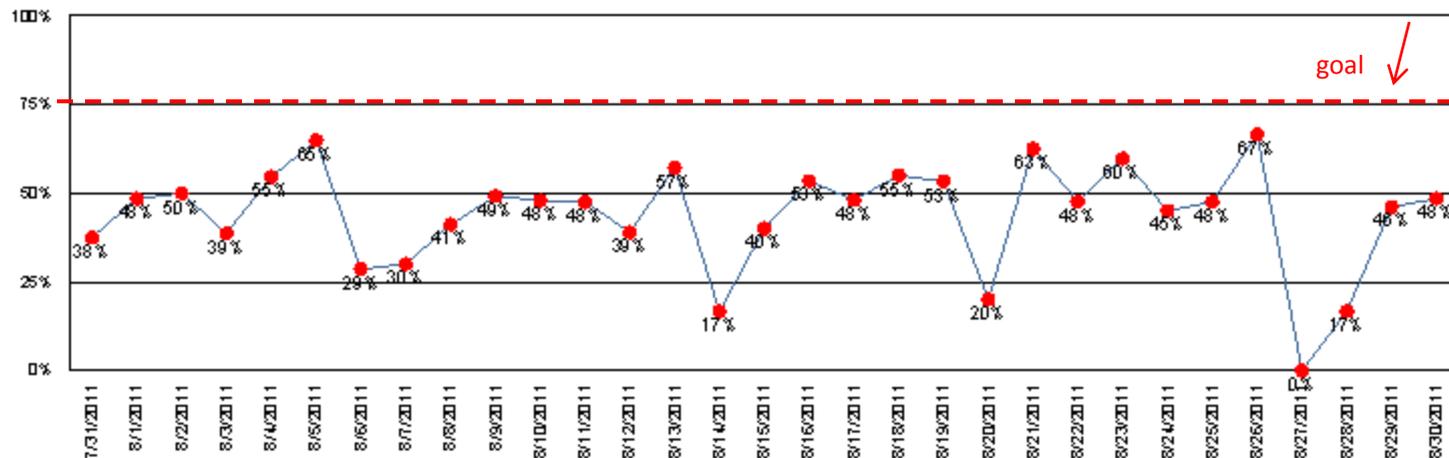
Report Description: Percent of Telephone Encounters closed within 4 hours of being generated.
Goal: 75% of all Telephone Encounters opened are resolved and closed within 4 hours of being generated.

8/31/2011

From 8/1/11 To 8/31/11

EVERETT CLINIC SNOHOMISH

For EVERETT CLINIC SNOHOMISH



EMR Front Page (“Snapshot”)

Standard Work

- After Visit Summary
- Lab Results Review
- Telephone Encounter
- Standard Rooming

Primary Care Visit Tools

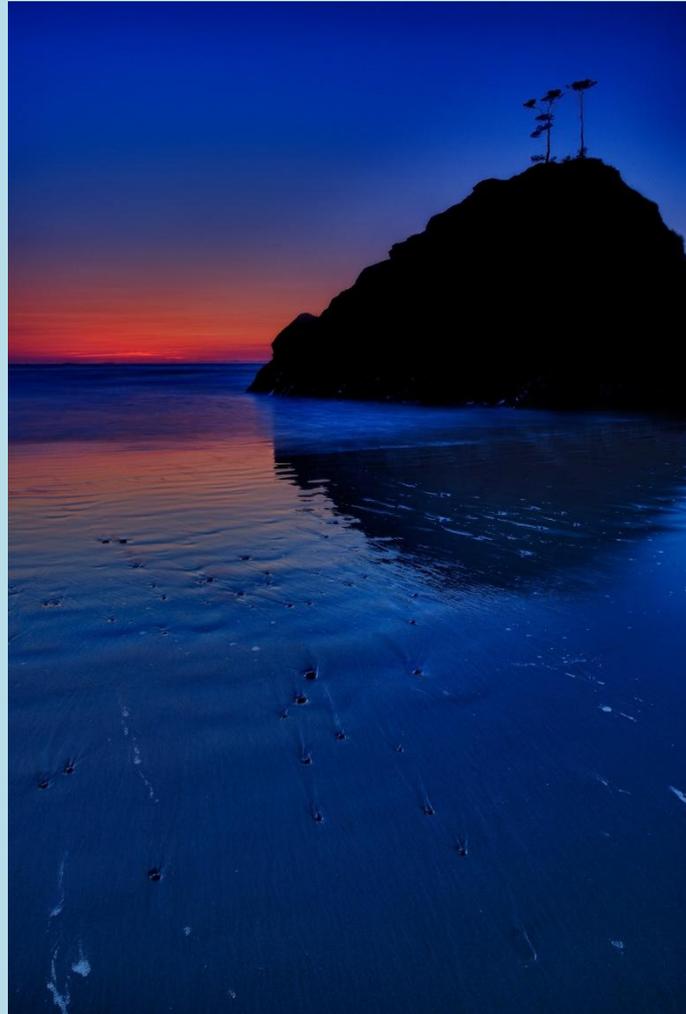
- Smart Sets
- Documentation Tools
- Coding Tools
- Evidenced-Based Imaging
- Pre-Visit Planning
- Problem List Prioritization

Information Flow Management

- Send This ...
- Don't Send This ...
 - Normal mammograms
 - Normal EGDs
 - Normal colonoscopies
 - Follow-up visit notes with no significant changes

Conclusion

- Identifying patients can be done through a variety of mechanisms
- Care management programs are key, require teams and continuous improvement
- All programs can be developed incrementally, but will take time, energy, and resources
- Electronic systems and reports are helpful in improving the identification, documentation, and tracking of patients





Module 3B. Connecting Providers and Managing High-Risk Patients

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